

# Med-Pay, Inc.

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## Claim Reimbursement Form COVID-19 Over-the-Counter (OTC) Tests

Complete and submit this form along with your receipt by:  
mail, fax, email (listed above) or through "Contact Us" on [www.med-pay.com](http://www.med-pay.com).

Please provide all requested information to prevent delays in the reimbursement of your claim.

Group #:	Group Name:		
Employee Name:			
Date of Birth:	Medical ID #:		
Employee Address:	Address	City	State Zip
Contact information:	Phone number:	Email address:	

UPC on package: (12-digits near barcode)	# of Test packages purchased:	# of Tests in each package:
Manufacturer of test:		

Claimant Name:	# of tests to allocate to this claimant:
Date of Birth:	Relationship to Employee: ___ Self ___ Spouse ___ Child
Employee Attestation: _____ (initial here)	I attest that this test(s) is for personal use, not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.

Claimant Name:	# of tests to allocate to this claimant:
Date of Birth:	Relationship to Employee: ___ Self ___ Spouse ___ Child
Employee Attestation: _____ (initial here)	I attest that this test(s) is for personal use, not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.

**Note: Receipt MUST be included.**

If filing claim reimbursement for more than two claimants, please complete and submit additional forms.

\_\_\_\_\_  
Employee's Signature  
(Print and sign or use Adobe digital signature)

\_\_\_\_\_  
Print Employee's Name

\_\_\_\_\_  
Date

If you have any questions, contact Med-Pay's Customer Service Department  
(417) 886-6886 or (800) 777-9087